

**DRVD  
CONFIDENTIAL REPORT**

**AN INVESTIGATION INTO AN ALLEGATION OF INAPPROPRIATE OR  
EXCESSIVE MEDICAL TREATMENT**

**Thirty-seven year-old, mentally retarded, female client at the Central Virginia  
Training Center in Lynchburg, Virginia, allegedly subjected to inappropriate  
feeding and medical treatment by CVTC staff members.**

**DRVD CASE# 98-0087 DD  
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**I. INTRODUCTION:**

This report is a summary of the findings from an investigation conducted by the Department for Rights of Virginians With Disabilities (DRVD) into the allegation of inappropriate medical treatment of a 37 year-old Caucasian female client at Central Virginia Training Center (CVTC), in Lynchburg, Virginia. Allegedly, the client:

- was refused admission to CVTC's acute care hospital when she was unresponsive on March 6, 1998;
- was subjected to multiple and prolonged insertions, and removals, of Nasal Gastrostomy (NG) tubes which were not medically indicated; and
- was at-risk of continued medical treatment problems due to the atmosphere created between CVTC and the family over the use of a G-Tube.

DRVD conducted this investigation of alleged abuse or neglect of an individual with developmental disabilities pursuant to the Developmental Disabilities Assistance and Bill of Rights Act of 1994. The investigation was conducted jointly with the assigned abuse investigator at CVTC and a Department of Mental Health, Mental Retardation, and Substance Abuse Services (DMHMRSAS) human rights advocate at CVTC.

This investigation included the following:

1. Review of the client's CVTC records;

2. Review of CVTC's administrative investigation report;
3. Interviews with the client and direct care staff members at CVTC including, but not limited to, the client's nursing staff, program manager, social worker, physicians, OT, and PT staff;
4. Discussion with the client's immediate family; and
5. Review of the CVTC Policy Manual.

This investigation also included a report prepared by a board certified M.D. as an expert reviewer who was by DRVD to determine whether the client's treatment met applicable standards of medical care.

## **II. BACKGROUND:**

CVTC is a state facility for persons with mental retardation, which is operated by the DMHMRSAS and has a population of approximately 700 clients. In addition to the resident living areas, CVTC operates an acute hospital, which provides in-patient hospital care. The hospital is located on the grounds of CVTC directly across from the skilled nursing care unit where the client resides. Clients may be admitted for medical-surgical treatment, observation, and/or diagnostic testing. The Medical Clinic provides 24-hour emergency services as part of the medical hospital system operated by CVTC. CVTC provides the following medical services: 24-hour physicians' service, dental, pharmacy, radiology, laboratory, respiratory therapy, orthopedic, and the outpatient clinic, which provides contracted specialty medical services clinics as needed.

The client was admitted to CVTC on March 12, 1968. The client is diagnosed as Mentally Retarded, Severity Unspecified, and has severe physical disabilities including Seizure Disorder; Cerebral Palsy; Kernicterus (onset at birth); Osteoporosis; Athetosis; Free GE reflux; Anemia; and Arrested Development. In addition, the client has spasticity, recurrent elevated temperature, probable hearing loss, visual impairments, recurrent bronchitis, and mucus congestion. The client also is unable to chew, engage in self-care, or maintain independent sitting balance.

## **III. CIRCUMSTANCES SURROUNDING THE ALLEGED INCIDENTS:**

### **A. Refused Admission to CVTC Acute Hospital on March 6, 1998**

The client's brother, who is a physician, contacted DRVD on April 2, 1998 and asked for DRVD's help. The client's brother alleged that on March 6, 1998 the client had been found unconscious and had been "...misdiagnosed as post-ictal when she actually has dangerously high and toxic Tegretol levels." The CVTC acute care hospital on-call physician, Dr. Divinia M.

Bautista, refused to admit the client even after the client's father told her that "...unconsciousness is not typical of her post-seizure behavior..." the client was also given "...at least one additional dose of Tegretol." The client's brother stated that a "...nasogastric tube (NG tube) was placed that night to give these extra medicines to an already toxic and unconscious patient."

According to the client's CVTC record and interviews with staff, on March 5, 1998, Dr. Bautista, a pediatrician, was the on-call physician at the CVTC Acute Hospital and refused to admit the client. At 8:30 PM, the client had presented to the unit Psychiatric Practical Nurse (PPN) as lethargic, unresponsive, and unable to take her scheduled medications. The PPN notified the Medical Clinic and the 2nd shift Registered Nurse (RN) nursing supervisor. The PPN covering the client's area escorted the client to the medical clinic in the hospital. Dr. Bautista observed that the client was lethargic, but that her vital signs were within normal limits, her oxygen levels were acceptable, and that the client did not show any "distress". The physician stated, "My impression was that she [the client] was post-ictal".

During an interview with the 2nd shift RN, the RN indicated that despite her insistence that evening that the client's condition was not her usual Post-Ictal (post-seizure) symptoms, the client was not admitted to the acute care hospital. Dr. Bautista ordered the staff to withhold the client's Tegretol dose until 10 PM, omit the Valium, and return her to her unit. The client was returned to her unit by 9:30 PM. There is no documentation in the record that Dr. Bautista conducted a complete assessment of the client. The client's CVTC record indicated that Dr. Bautista ordered lab work for the next day, March 6, 1998. When the client's lab work was completed the next day, it revealed that the client was Tegretol Toxic rather than post-ictal as the physician had indicated the night before.

According to interviews with CVTC staff and the client's father and brother, the client's father had been made aware of the situation when he called the unit PPN at 9:55 PM. The client's father spoke with Dr. Bautista when he arrived at CVTC later. He asked the physician to admit the client. The 2nd shift RN and the client's father reported that Dr. Bautista again refused to admit the client. Yet, in two separate interviews with Dr. Bautista, she denied that the client's father asked her to admit the client to the hospital and stated that he agreed with her decision not to admit the client.

## **B. Multiple Insertions and Removals of NG Tubes**

The client's brother alleged that in March 1998, the client had "...suffered recently from multiple insertions, removals, and painful fixations resulting in external and internal ulceration, mucosal bleeding, and marked nasal deformity from tube being taped under extreme tension". He alleged there had "...been prolonged use of NG tubes for no medical reason (except that it is easier and quicker to feed [the client])." Based on the client's CVTC record, there were multiple insertions and removals of NG tubes, sometimes within one day, during March and early April 1998. During that time, the client was admitted several times to the CVTC Acute Hospital with bronchitis and possible pneumonia. Meanwhile, staff members had trouble administering medications and nutritional supplements orally. In the client's CVTC record, there is a standing PRN order for use of the NG tube. In interviews with the Human Service Care Workers and an evening shift LPN who work with the client regularly, they stated they were usually able to get the client to take her nutritional supplements. If one staff member was unsuccessful, another would try, or they would wait until later to try again. While these staff members were generally successful, the nurses who were not as familiar with the client resorted to invoking the standing PRN order to use a NG tube to accomplish feeding and/or medicating the client.

According to interviews with the client's nurses, when they were unsuccessful in administering medications, the physician ordered them to enact the standing PRN order to insert a NG tube to feed and administer medications and then remove the tube when the feeding was completed. In the interviews, some staff stated they had little difficulty feeding the client orally while others stated they had great difficulty feeding the client without the NG tube. Although there was conflicting testimony regarding the level of success individual staff members had in feeding or giving the client medications, all agreed that during menses or when the client was sick it was more difficult than usual to successfully medicate or feed the client.

According to the client's CVTC record, on March 11, 1998, a NG tube was in place and the client "tolerated her feedings well". On March 12, the client was "noted to pull NGT [tube] out" and was "extremely spastic." CVTC staff was able to feed the client by mouth and did not reinsert a NG tube.

On March 13, 1998, the client was admitted to the CVTC Acute Hospital for further observation, evaluation, and treatment for fever, vomiting,

bronchitis, and dehydration, and to rule out aspiration pneumonitis. From 3/13/98 until 3/17/98, she remained at the hospital and received intravenous (I.V.) fluids and medications. On 3/17/98, a NG tube was inserted for feeding. The I.V. fluids were discontinued on 3/18/98 and the client was discharged from the CVTC Acute Hospital back to her living area with a NG tube inserted and discharge orders to continue the use of the NG tube.

The client's CVTC record documents that on 3/22/98, at 6AM, the NG tube was "noted to be out" by nursing staff. A NG tube was then inserted "with difficulty due to spasticity of client". At 8:30 AM, the NG tube was replaced because nursing staff was unable to aspirate and auscultate due to a kink on the end of the tube. Staff reported difficulty replacing the tube because of the client's movements. A NG tube was used until 3/25/98 when the record reports it was out. There was no documentation that a NG tube was reinserted at that time.

On 3/26/98, the physician ordered insertion of a NG tube to administer liquid diet and medications, and removal after completing the feeding. A NG tube was used twice on 3/26/98 for this purpose. Later on 3/26/98, the client was admitted to the CVTC Acute Hospital with bronchitis and to rule out aspiration pneumonia. The client received I.V. fluids from 3/26/98 to 3/30/98. On 3/30/98, a NG tube was inserted and the client was discharged back to her living area on 4/1/98 with the NG tube in place. From 4/1/98 to 4/4/98, it was reported that the client tolerated her NG tube feedings well and the tube remained in place.

On 4/4/98, the NG tube was observed to be out and the physician ordered it replaced. That NG tube was used from 4/4/98 to 4/8/98, when it was removed after the 4/7/98 midnight feeding.

### **C. Negative Atmosphere Created over G-Tube Surgery**

The client's brother reported that CVTC staff told the family that CVTC would pursue surgical G-tube insertion over their objection. The family felt that CVTC was attempting to coerce concurrence for the tube.

On March 23, 1998 the client's family met with the CVTC facility director and medical staff to discuss the client's feeding and treatment. The family, CVTC's director, and the medical staff agreed at that meeting on a course of treatment for the client (which did not include G-tube surgery) and a protocol to follow for feeding the client. CVTC staff was required to notify the family prior to using a NG tube to feed or medicate the client.

On March 26, 1998, contrary to the agreement that had been reached with the client's family on March 23, 1998, the CVTC physician ordered a modified, or cookie swallow evaluation by the nutritional management team. Nurse Young admitted that a NG Tube was inserted that morning to give medication and treatment to the client without notifying the family. CVTC had ordered an evaluation and treatment contrary to the agreement.

A review of the client's CVTC records and interviews with staff reveal that there has been recurring discussion among CVTC staff and with the client's family, including the client's brother and father, concerning surgical insertion of a G-tube. The discussions generally occur when it is time for the client's annual review, when she has an episode of aspiration pneumonia, and NG tubes are medically indicated for the duration of her illness, or when a staff member who does not regularly feed the client has difficulty feeding her. The most recent discussions prior to the client's brother's complaint occurred during March and April 1998 when the client was admitted several times to the CVTC acute hospital with bronchitis and possible pneumonia.

The client's father and brother also alleged that a CVTC Social Worker said, 'the doctors will put it [G-tube] in anyway, even without consent, for [the client's] best interests'. In an interview with the social worker, the social worker denied ever stating that to a family member. A review of the record and interviews with staff did not reveal any evidence which showed that CVTC ever scheduled the client for the G-tube surgery nor that CVTC had pursued any legal steps to obtain an order for a surgical G-tube.

Nurse Young admits that she has told the client's father that she felt like she was killing the client by feeding her and that she had multiple conversations with the family about the necessity of a G-Tube for the client. Nurse Young has since been to classes regarding the G-Tube and at the time of the interview felt conflicted about the best approach to feeding. Other staff admitted to believing that the client needed the G-Tube but did not feel they had coerced the family. Staff admitted to knowledge of the family's desires regarding the G-Tube and other staff's opinions about not needing to use a G-Tube.

#### **IV. FINDINGS AND CONCLUSIONS:**

Based on this investigation, DRVD's findings are as follows:

1. The CVTC on-call physician failed to recognize the significance of the client's physical symptoms on March 6, 1998 and failed to conduct a full

assessment of the clinical condition of a client with a change in level of consciousness. The CVTC on-call physician also failed to provide timely acute medical care services to evaluate those symptoms.

This investigation revealed that the CVTC policies titled "Medical Clinic Services" and "Admission to Acute Hospital" established that 2nd and 3rd shift staff are to refer any client in need of medical services directly to the CVTC hospital clinic medical staff. Once the clinic receives notification, the medical staff personnel are responsible for treatment. According to the expert reviewer, in this case, Dr. Bautista refused to admit and failed to conduct a complete assessment of a client with a change in level of consciousness to the CVTC Acute hospital, despite unit staff attempts to have the client admitted. A complete assessment may have indicated a different diagnosis and a different course of treatment for the client.

According to the expert reviewer:

While the patient may not have needed to be admitted to the acute care facility following a change in mental status, a full assessment of her clinical condition should have been made in order to render appropriate care. Appropriate care was not rendered.

The expert reviewer also concluded that:

Regarding the issue of change in mental status, I believe the medical record showed that the evaluation of the patient's mental status change was not complete. In most cases, the episode would have been attributable to a post-ictal state. However, Tegretol toxicity is known to cause acute confusional states, and [the client's] father alerted that [sic] -medical staff that she was not "typically post-ictal." The clinical team should have known that this patient had been taking other medications, which would have increased the serum Tegretol levels. A Tegretol level should have been obtained that evening, and all medications should have been held pending that result. This episode in the patient's care clearly did not meet medical standards of care.

Therefore, it is concluded that the CVTC physician failed to recognize the significance of the client's physical symptoms and failed to conduct a full assessment of the clinical condition of a client with a change in level of consciousness. The CVTC physician also failed to provide timely acute medical care services to evaluate those symptoms.

2. CVTC failed to meet the acceptable standards of care with regards to NG tube use.

According to the expert reviewer's report, "[m]edical care with regard to the issues identified had not met standards of acceptable care." Regarding NG tube use, the expert reviewer stated:

The nasogastric tube was used to prevent aspiration of food and to maintain nutritional status in the care of [the client]. Careful feedings, which followed the recommendations of a barium swallow performed in 1995, would have been clinically preferable. The nasogastric tube appeared to be overused in the care of [the client].

According to the expert reviewer, the overuse is corroborated by the documentation in the record of numerous NG tube insertions and removals.

3. CVTC's actions have contributed to a non-productive atmosphere over the client's treatment and the family's decision not to consent to G-tube surgery.

During the interviews with staff, many of them opined that the client would benefit from G-tube placement, as she is difficult to feed. It was also evident that while staff members espouse differing views as to the client's need for G-tube surgery and as to the risks and benefits of this surgery, they are aware of other staff opinions and the family's conflicting desires. All deny any subversive attempts to "prove" the client should have G-tube surgery by excessive use of NG tubes or by discontinuing efforts to feed/medicate her during the times she is more difficult to feed. This investigation did not uncover any documentation of a plan for CVTC to pursue a court order for G-tube surgery without the family's consent. Given the level of the family's medical knowledge and involvement, it would seem unlikely CVTC would pursue in this manner. However, the combination of staff's failure to follow agreed upon procedures for contacting the family prior to evaluation or treatment for feeding, along with continuing discussion of the need for a G-Tube, and a nurse telling the family that she felt she was "killing the client" by feeding her the family's preferred way has contributed to an atmosphere of mistrust.

## **V. RECOMMENDATIONS:**

The following recommendations are based on the findings and conclusions of this investigation and the expert reviewer's report:



1. CVTC should develop a policy that requires the on-call acute hospital physicians to perform a complete, timely assessment when staff and/or authorized family members request such, or whenever abnormal or serious symptoms for a specific resident are reported.
2. CVTC should, based on the expert reviewer's report, educate staff members regarding the difference between post-ictal and toxic mental status changes in order to avoid potentially serious medical emergencies involving toxic states.
3. CVTC must review its policy on NG tube use and provide in-service training for nursing staff regarding the appropriate use of NG tubes and less invasive alternative procedures for feeding and medicating.
4. CVTC must, based on the expert reviewer's report, consult with an expert in the field of Gastrostomy tube placement for swallowing disorders in this special population. While an expert in Gastrostomy tubes might be inclined to recommend tube placement, the clinical questions should be phrased to elicit the conditions under which this surgical procedure would be recommended for this patient.
5. CVTC must have an authorized representative for each and every resident who shall be contacted and informed about the contemplation of any invasive medical procedure and without whose consent the procedure shall not take place.
6. CVTC must assure that its staff physicians obtain sufficient and appropriate continuing medical education as a condition of employment to qualify them to diagnose and treat the facility population.
7. CVTC staff must cease and desist from alienating interested family members concerned with the care of their own daughter or son or sibling. Reassignment of the patient's treatment team in accordance with the family's wishes is recommended.

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